# PERMIT APPLICATION

WOBURN BOARD OF HEALTH
10 Common Street
Woburn, MA 01801
781-897-5920
FAX: 781-897-5929

Est. Name: ______________________

Address: ______________________

Mailing Address: ______________________

City, State, Zip: ______________________

Establishment Phone: ______________________

**OWNER'S INFORMATION:**

Owner: ______________________

Address: ______________________

City, State, Zip: ______________________

Phone: ______________________

Email: ______________________

**EMERGENCY CONTACT:**

Name: ______________________

Title: ______________________

24HR Emer. #: ______________________

Email: ______________________

**ESTABLISHMENT INFORMATION:**

Hours of Operation: ______________ If seasonal, date open: ________ date close: ________

Certified Food Protection Manager(s): ______________________

Person(s) Trained in Anti-Choking (required for food establishment with 25 seats or more): ______________________

**Tanning**: # of beds in establishment: ______________________

**Stables:** Type of animals: ______________ #of animals: ________

Name of Veterinary: ______________________ Phone: ______________________

Address: ______________________

If Corporation or Partnership, please list Name, Title, & Home Address of Officers/ Partners: Attach if necessary.

| **NAME:** | **TITLE:** | **ADDRESS:** |
|---|---|---|
| | | |
| | | |
| | | |

| TYPE OF PERMIT: | FEE: | TYPE OF PERMIT: | FEE: |
|---|---|---|---|
| ☐ Supermarket | $ 100.00 | ☐ Tanning | $ 50.00 |
| ☐ Retail Food | $ 50.00 | ☐ Stable | $ 25.00 |
| ☐ Food Service | $ 50.00 | ☐ Pool | $ 50.00 |
| ☐ Elderly Care or Day Care | $ 50.00 | ☐ Spa | $ 50.00 |
| ☐ Caterer | $ 50.00 | ☐ Wading Pool | $ 50.00 |
| ☐ Church | $ No Charge | | |
| Check if also using or selling: | | | |
| ☐ Milk, Cream, Ice Cream | $ 4.00 | Total Payment Due: $_____ | (Make check payable to **City of Woburn**) |
| ☐ Tobacco | $ 50.00 | | |

**I, the undersigned, attest to the accuracy of the information provided in this application and I affirm that the food establishment operation will comply with 105 CMR 590.000 and all other applicable laws. I certify under penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid state taxes required under law pursuant to MGL Ch. 62C, sec. 49A.**

Signature: ______________________ Date: ______________________

Print Name: ______________________ Social Security or FID#: ______________________

***PLEASE REMEMBER TO INCLUDE THE WORKER'S COMP FORM AND THE CERTIFCATION OF TREASURER AND COLLECTOR'S FORM.**

# CERTIFICATION OF TREASURER/COLLECTOR

(MGL c.40,§57; WMC 3-24)

*Office Use Only: DEPARTMENT*

**BOARD OF HEALTH**

**** FAXES OR SIGNATURE COPIES WILL NOT BE ACCEPTED ****

**NOTE - ALL LINES MUST BE COMPLETED. If any line is not applicable please write "N/A"**

**Property Address where permit is sought:**______________________________
Real Estate/Property Owner Name(s):______________________________
Real Estate/Property Owner(s) Legal Business Name *(if any)*:______________________________
Real Estate Owner's Residential Address *(if different)*:______________________________
Telephone Number:______________________________

Tenant/Lessee Legal Business
Name:______________________________
Business Owner Personal Name(s) *(if any)*______________________________
Owner(s) Address: ______________________________ Telephone Number: ______________

**Check one:** ☐ Residential ☐ Individual/Sole Proprietor ☐ Corporation
☐ Trust ☐ Other ______________________________

**APPLICANT TO COMPLETE: Failure to complete may result in delay of permit processing.**

*Parcel which directly relates to the application filed for which certification is sought. (***This numeric I.D. can be found: http://data.visionappraisal.com/WoburnMA/, on a tax bill, at the Building or Assessors offices***).

**(Example I.D.: 12-34-56)** Map ______________ Block ______________ Lot ______________

****REQUIRED: Does Real Estate owner and/or tenant own or have a beneficial or financial interest in any other real estate properties within the city of Woburn?** ***Circle one:*** **NO YES**

A beneficial interest can be as an individual, partnership, trust, LLP, etc. If **YES**, insert Map, Block, and Lot below for each property. Use back of form, if necessary.

Map ______________ Block ______________ Lot ______________
Map ______________ Block ______________ Lot ______________

**I certify under the penalties of perjury that I am the record owner or tenant of the within described property and the above information is accurate and complete.**

______________ ______________________________
Date Signature of Applicant Property Owner or Tenant-- (Not contractor)

______________ ______________________________
Title Print Name

***(For Office Use Only)*** **CERTIFICATION OF TREASURER/COLLECTOR**

The records of this office indicate that there are no unpaid real estate taxes, municipal fees, liens or other municipal charges outstanding and unpaid, or for the payment of which the owner has entered into a payment agreement with this office, on the above described parcels as of:

______________
Certification Date

EXPIRES: ______________
(Residential Only)

______________
Treasurer/Collector

*The Commonwealth of Massachusetts*
*Department of Industrial Accidents*
*Office of Investigations*
*600 Washington Street*
*Boston, MA 02111*
*www.mass.gov/dia*

## Workers' Compensation Insurance Affidavit: General Businesses

**Applicant Information** **Please Print Legibly**

Business/Organization Name:____________________________________

Address:____________________________________

City/State/Zip:__________________ Phone #:__________________

**Are you an employer? Check the appropriate box:**

1. ☐ I am a employer with ________ employees (full and/ or part-time).*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
3. ☐ We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

**Business Type (required):**

5. ☐ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other __________________

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.
**If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

***I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.***

Insurance Company Name:____________________________________

Insurer's Address:____________________________________

City/State/Zip: ____________________________________

Policy # or Self-ins. Lic. #______________________ Expiration Date:____________

**Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).**

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to $1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to $250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

***I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.***

Signature:____________________________ Date:______________

Phone #:____________________________________

*Official use only. Do not write in this area, to be completed by city or town official.*

**City or Town:** ____________________ **Permit/License #**__________________

**Issuing Authority (circle one):**
**1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office**
**6. Other** __________________

**Contact Person:**______________________ **Phone #:**__________________